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Issue Date: 19 October 2005

In the Matter of:
ROY MONROE BEVERLY
Claimant

v. Case No. 2004-BLA-00141

CLINCHFIELD COAL COMPANY
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-In-Interest

Before: Daniel F. Solomon
Administrative Law Judge

DECISION AND ORDER - DENYING CLAIM[1]

JURISDICTION AND CLAIM HISTORY

This case comes on a request for a hearing pursuant to the provisions of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. §§ 901 *et seq*. (the Act) (DX-72)[2] dated March 29, 2004.[3]

Procedural Background

A hearing was held on April 5, 2005, in Abington, Virginia. The Claimant is represented by Ron Carson, Stone Mountain Health Services, St. Charles, Virginia. Clinchfield Coal Company (hereinafter "Employer") is represented by H. Ashby Dickerson, Esq., Penn Staurt, Abingdon, Virginia. An appearance was entered for the Director, OWCP, who was not represented at the hearing. The Claimant's daughter appeared at the hearing and testified.

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[1] 20 C.F.R. § 725.477, 5 C.F.R. § 554-7 (Administrative Procedure Act), and also 20 C.F.R. § 725.479 Finality of decisions and orders.

[2] References to "ALJX", "CX", "DX" and "EX" refer to the exhibits of the Administrative Law Judge, Claimant, Director and the Employer, respectively. The transcript of the hearing is cited as "Tr." and by page number.

[3] And the regulations at 20 C.F.R. Ch. VI, Subchap. B (the Regulations).

Seventy Six (76) Director's exhibits, DX-1 through DX-76,[4] thirteen (13) Claimant's exhibits, CX 1 and CX 13,[5] and twenty seven (27) Employer's exhibits, EX 1 through EX 27,[6] were admitted into evidence at the formal hearing.

The Claimant, Roy Monroe Beverly, filed his first claim for benefits under the Act on September 26, 1984. (DX-42-1). This claim was denied by the District Director on March 28, 1985 (DX-42-12), and the Claimant requested a formal hearing by letter dated April 3, 1985. (DX-42 13). This request was accompanied by additional evidence, and the District Director apparently treated it as a request for reconsideration or modification, for the District Director administratively closed the claim after finding that the new evidence did not change the denial of benefits. (DX-42-17). On April 24, 1986, this claim was referred to the Office of Administrative Law Judges for a formal hearing. (DX-42-26). On April 13, 1988, Administrative Law Judge Gerald T. Hayes issued a Decision and Order denying benefits. (DX-42). Administrative Law Judge Hayes found that the Claimant suffers from pneumoconiosis, but that he was not totally disabled. The denial of benefits was affirmed on appeal to the Benefits Review Board. ***Beverly v. Clinchfield Coal Company***, BRB No. 88-1404 BLA (Feb. 28, 1990) (unpub.).

The Claimant filed a duplicate claim for benefits on February 14, 1995. (DX-43). On August 10, 1995, this claim was administratively denied, with the District Director finding that the Claimant failed to establish any element of entitlement. (DX-43). On April 10, 1996, the District Director issued a proposed decision and order denying benefits. (DX-43). The Claimant took no action in response to this decision.

On May 12, 1997, he filed a second duplicate claim. (DX-1). On September 19, 1997, the District Director denied this claim, finding that the Claimant failed to establish total respiratory disability. (DX-24). This claim went before Administrative Law Judge Jeffrey Tureck for a formal hearing, and on September 25, 1998, Judge Tureck issued a Decision and Order Denying Benefits, finding that the Claimant failed to establish total respiratory disability, and thus failed to establish a material change in conditions. (DX-47).

The Claimant requested modification of the denied second duplicate claim, filing a petition for modification on September 9, 1999. (DX-48). On October 15, 1999, the District Director issued an order requiring the employer to show cause why modification should not be granted. (DX-48A). The employer submitted additional evidence in response, and on March 4, 2000, the District Director issued a *Proposed Decision and Order Denying Request for Modification.* (DX-55). The Claimant on March 28, 2000 requested a formal hearing. (DX-57). The Claimant also submitted additional evidence in support of the claim. (DXs-58, 59). Following an informal conference, the District Director on December 7, 2000 issued a *Memorandum of Informal Conference* upholding the earlier administrative denial and denying the claim on the basis of the Claimant's failure to establish total respiratory disability. (DX-64). On November 20, 2001, the Claimant submitted additional evidence in support a renewed request for modification. (DX-66). The District Director, on March 14, 2002, issued a *Proposed*

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[4] At Tr. 6.

[5] At Tr. 13-14. The employer has filed a motion to exclude exhibits. In view of the disposition of this claim, this motion is denied as moot.

[6] At Tr. 23-29.

Order to Show Cause Granting Request for Modification. (DX-70). The employer responded with additional medical evidence. On March 22, 2004, the District Director issued a *Proposed Decision and Order Granting Request for Modification*. (DX-71). Pursuant to the employer's request, this matter was referred to the Office of Administrative Law Judges for a formal hearing as noted above. (DX74).

Hearing Testimony

The Claimant's daughter testified at the hearing. She testified that she has seen that her father has suffered a progressively worsening health, and that he is limited in performing his everyday activities. (Tr. 36). When asked on cross-examination about smoking, she said that she could not recall often seeing Claimant smoke cigarettes. (Tr. 39).

APPLICABLE STANDARDS

Because the Claimant filed this application for benefits after March 31, 1980, the regulations set forth at Part 718 apply. ***Saginaw Mining Co. v. Ferda***, 879 F.2d 198, 204, 12 B.L.R. 2-376 (6th Cir.1989). This claim is governed by the law of the United States Court of Appeals for the Fourth Circuit, because the Claimant was last employed in the coal industry in the Commonwealth of Virginia within the territorial jurisdiction of that court. ***Danko v. Director, OWCP***, 846 F.2d 366, 368, 11 B.L.R. 2-157 (6th Cir. 1988). *See* ***Broyles v. Director, OWCP***, 143 F.3d 1348, 1349, 21 B.L.R. 2-369 (10th Cir. 1998); ***Kopp v. Director, OWCP***, 877 F.2d 307, 12 B.L.R. 2-299 (4th Cir. 1989); ***Shupe v. Director, OWCP***, 12 B.L.R. 1-200 (1989) (*en banc*).

A miner must prove that (1) he suffers from pneumoconiosis, (2) the pneumoconiosis arose out of coal mine employment, (3) he is totally disabled, and (4) his total disability is caused by pneumoconiosis. ***Gee v. W. G. Moore and Sons***, 9 B.L.R. 1-4 (1986) (en banc); ***Baumgartner v. Director, OWCP,*** 9 B.L.R. 1-65 (1986) (en banc). *See* ***Mullins Coal Co., Inc. of Virginia v. Director, OWCP***, 484 U.S. 135, 141, 11 B.L.R. 2-1 (1987). The failure to prove any requisite element precludes a finding of entitlement. ***Anderson v. Valley Camp of Utah, Inc.***, 12 B.L.R. 1-111 (1989); ***Perry v. Director, OWCP***, 9 B.L.R. 1-1 (1986) (*en banc*).

ISSUE

This decision relates to the modification of a duplicate claim filed on September 20, 2000. DX-1. Because the claim at issue was filed after March 31, 1980, the regulations at 20 C.F.R. Part 718 apply.[7] 20 C.F.R. § 718.2 (2002). In reaching my decision, I have reviewed and considered the entire record, including all exhibits, the testimony at hearing and the arguments of the parties.[8]

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[7] The Department of Labor has amended the regulations that implement the Act. *See* 65 Fed. Reg. 80,045-80,107 (2000). The adjudication of this claim is subject to regulations as amended effective January 19, 2001 that relate to the standards of entitlement. 20 C.F.R. § 718.2 (2001). Unless otherwise indicated, citations are to the regulations as amended. Because this claim was "pending" on January 19, 2001, however, the provisions of the amended regulations that both govern "subsequent claims," modification and that limit the development of medical evidence do not apply to the consideration of claimant's petition for modification of the 2000 duplicate claim. 20 C.F.R. § 725.2(c). *See* 68 Fed. Reg. 69935 (Dec. 15, 2003). A claim shall be considered "pending" if it was not finally denied more than one year prior to January 19, 2001, the effective date of the amended regulations. 20 C.F.R. § 725.2(c).

[8] The entire record has been reviewed *de novo*, because the Claimant has established a material change in conditions with proof of total respiratory disability.

The specific issue for adjudication in this case is whether the medical evidence of record establishes that the Claimant's total respiratory disability is caused by pneumoconiosis.[9] Because he has established total respiratory disability, Mr. Beverly's claim will be considered on the basis of the administrative record as a whole.

STIPULATION AND WITHDRAWAL OF ISSUES

Without stipulating to that fact at the formal hearing, counsel for the employer acknowledged that there was evidence that the Claimant is totally disabled. (Tr. 20). In its post-hearing brief, the employer has acknowledged that the Claimant suffers from a totally disabling pulmonary or respiratory impairment. Because total respiratory disability was an element adjudicated against the Claimant in the earlier claim, the record as a whole shall be evaluated to determine whether the Claimant is entitled to benefits. *See* ***Lisa Lee Mines v. Director, OWCP*** [***Rutter***], 86 F.3d 1358, 1362-63, 20 B.L.R. 2-227 (4th Cir. 1996) (en banc), *cert. denied*, 519 U.S. 1090 (1997); ***Cline v. Westmoreland Coal Co.***, 21 B.L.R. 1-69 (1997).

The length of the Claimant's qualifying coal mine employment is not contested as an issue, with the parties stipulating to a at least 28 years of coal mine employment.

BURDEN OF PROOF

"Burden of proof," as used in the this setting and under the Administrative Procedure Act[10] is that "[e]xcept as otherwise provided by statute, the proponent of a rule or order has the burden of proof." "Burden of proof" means burden of persuasion, not merely burden of production. 5 U.S.C. § 556(d).[11] The drafters of the APA used the term "burden of proof" to mean the burden of persuasion. ***Director, OWCP, Department of Labor v. Greenwich Collieries*** [***Ondecko***], 512 U.S. 267, 18 B.L.R. 2A-1 (1994).[12]

A Claimant has the general burden of establishing entitlement and the initial burden of going forward with the evidence. The obligation is to persuade the trier of fact of the truth of a proposition, not simply the burden of production, the obligation to come forward with evidence to support a claim. Therefore, the Claimant cannot rely on the Director to gather evidence. The

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[9] This implicates what would be described as a question of "general causation." As was recently pointed out by the Second Circuit:

> General causation bears on whether the type of injury at issue can be caused or exacerbated by the defendant's product. "Specific" causation bears on whether, in the particular instance, the injury actually was caused or exacerbated by the defendant's product.

Ruggiero v. Warnet-Lambert Co., et al., ___ F.3d ___, ___ n. 1, No. 04-6674-cv, slip op. 4 n. 1 (2d Cir. Sept. 16, 2005) (emphasis in original) (citing ***Amorgianos v. Nat'l R. R. Passenger Corp.***, 303 F.3d 256, 268 (2d Cir. 2002)). The question as to whether pneumoconiosis can cause lung cancer is a matter of general causation. If there is no etiological correlation between the two diseases, that fact would preclude the "special causation" inquiry of whether the Claimant's pneumoconiosis *in this case* caused or contributed to the Claimant's cancer and the total respiratory disability resulting from that malignancy.

[10] 33 U.S.C. § 919(d) ("[N]otwithstanding any other provisions of this chapter, any hearing held under this chapter shall be conducted in accordance with [the APA]"); 5 U.S.C. § 554(c)(2). Longshore and Harbor Workers' Compensation Act ("LHWCA"), 33 U.S.C. § 901-950, is incorporated by reference into Part C of the Black Lung Act pursuant to 30 U.S.C. § 932(a).

[11] The Tenth and Eleventh Circuits held that the burden of persuasion is greater than the burden of production, ***Alabama By-Products Corp. v. Killingsworth***, 733 F.2d 1511, 6 B.L.R. 2-59 (11th Cir. 1984); ***Kaiser Steel Corp. v. Director, OWCP*** [***Sainz***], 748 F.2d 1426, 7 B.L.R. 2-84 (10th Cir. 1984). These cases arose in the context where an interim presumption is triggered, and the burden of proof shifted from a Claimant to an employer/carrier.

[12] Also known as the risk of nonpersuasion, *see* 9 J. Wigmore, **Evidence** § 2486 (J. Chadbourn rev. 1981).

Claimant bears the risk of non-persuasion if the evidence is found insufficient to establish a crucial element. ***Oggero v. Director, OWCP***, 7 B.L.R. 1-860 (1985).

MEDICAL EVIDENCE

Introduction

This claim was referred to the Office of Administrative Law Judges from the administrative approval of the claim by the District Director. The Claimant had filed a petition for modification of an earlier administrative denial of his duplicate claim. At this juncture, there is no serious dispute but that the Claimant suffers from a totally disabling pulmonary or respiratory impairment. Because of this, Mr. Beverly has established the element of entitlement that had been adjudicated against him, and is now entitled to an adjudication of his claim for benefits on the basis of the entire administrative record. This fact essentially renders moot any inquiry under the procedures prescribed for the analyses of duplicate claims or modification.

Although all of the record is to be reviewed *de novo*, the evidence that was previously reviewed by other adjudicators and previously set forth will not again be listed herein in great detail unless necessary for a consideration of an issue. Without adopting earlier findings and conclusions, I do incorporate by reference those lists of exhibits and evidence as previously set forth. *See generally*, ***Wheeler v. Apfel*****,** 224 F.3d 891, 895 n. 3 (8th Cir. 2000).

The pertinent medical evidence includes the following that has been submitted pursuant subsequent to the Claimant's request for modification[13]:

X-Ray Interpretations

X-RAY DATE	***READ DATE***	***EXH***	***PHYSICIAN***	***CREDENTIALS***	***READING***
07-13-98	07-13-98	DX-51	Navani	B/BCR[14]	0/1
07-13-98	12-16-99	DX-53	Scott	B/BCR	no pneumoconiosis
07-13-98	12-17-99	DX-53	Wheeler	B/BCR	no pneumoconiosis
07-13-98	02-29-00	DX-56	Fino	B	no pneumoconiosis
12-06-99	12-07-99	DX-52	Castle	B	0/1
12-06-99	12-16-99	DX-53	Scott	B/BCR	no pneumoconiosis
12-06-99	12-1799	DX-53	Wheeler	B/BCR	no pneumoconiosis

[13] In order to assess whether the Claimant is entitled to reopen this duplicate claim pursuant to his request for modification, I must consider the duplicate claim record as a whole to determine whether the denial of the duplicate claim constitutes a mistake in determination of fact. I shall also review of the new "modification" evidence to assess whether it demonstrates a change in Mr. Beverly's condition.

[14] The credentials of interpreters of the x-rays are signified as "A" for an A-reader of x-rays, "B" for a B-reader, "BCR" for a board-certified radiologist, and "B/BCR" for a radiologist who possesses dual qualifications. A physician who is "board-certified" has received certification in radiology by the American Board of Radiology or the American Osteopathic Association. 20 C.F.R. § 718.202(a)(1)(ii)(C). *See* ***Staton v. Norfolk & Western Railway Co.***, 65 F.3d 55, 57, 19 B.L.R. 2-271 (6th Cir. 1995).

A "B reader" is a physician, often a radiologist, who has demonstrated proficiency in reading x-rays for pneumoconiosis by passing annually an examination established by the National Institute of Occupational Safety and Health and administered by the U.S. Department of Health and Human Services. *See* 20 C.F.R. § 718.202(a)(ii)(E); 42 C.F.R. § 37.51. Courts generally give greater weight to x-ray readings performed by "B-readers" over interpretations by physicians who possess no radiological qualification. *See* ***LaBelle Processing Company v. Swarrow***, 72 F.3d 308, 20 B.L.R. 2-76 (3d Cir. 1995).

An administrative law judge may properly defer to the readings of the physicians who are both B-readers and Board-certified radiologists. ***Roberts v. Bethlehem Mines Corp.***, 8 B.L.R. 1-211 (1985). *See* ***Zeigler Coal Co. v. Director, OWCP*** **[*Hawker*]**, 326 F.3d 894, 899, __ B.L.R. 2-___ (7th Cir. 2003). Finally, a radiologist's academic teaching credentials in the field of radiology are relevant to the evaluation of the weight to be assigned to that expert's conclusions. *See* ***Worhach v. Director, OWCP***, 17 B.L.R. 1-105 (1993).

12-06-99	02-29-00	DX-56	Fino	B	no pneumoconiosis
04-20-00	04-20-00	DX-61	Ramakrishnan	B	1/1
04-20-00	11-01-00	DX-60	Navani	B/BCR	quality 2, pleural abnormalities consistent with pneumoconiosis, such as pleural thickening and calcification – no opacities
04-20-00	06-14-02	DX-70B	Castle	B	0/1
11-07-00	11-16-00	DX-62	Castle	B	0/1
08-08-01	08-09-01	DX-66	Ramakrishnan	B/BCR	1/2
08-08-01	12-18-01	DX-70	Barrett	B/BCR	no pneumoconiosis
08-08-01	06-14-02	DX-70B	Castle	B	0/1
04-08-02	05-18-02	CX-1	Alexander	B/BCR	2/1
05-09-02	06-14-02	DX-70B	Castle	B	0/1
03-11-03	03-20-03	CX-2	Pathak	B/BCR	1/1
01-11-05	02-02-05	CX-3	Alexander	B/BCR	½
01-11-05	04-20-05	EX-28	Wheeler	B/BCR	quality 2, no pneumoconiosis
01-11-05	04-20-05	EX-29	Scott	B/BCR	quality 2, no pneumoconiosis
02-08-05	04-20-05	EX-30	Wheeler	B/BCR	quality 2, no pneumoconiosis
02-08-05	04-20-05	EX-31	Scott	B/BCR	quality 2, no pneumoconiosis

The recent evidence also contains unclassified readings, including two x-ray interpretations by Dr. Kathleen DePonte, dated March 18, 1998 and March 22, 1999, in which the doctor read films taken these dates as showing chronic obstructive pulmonary disease.

Biopsy Report

The Claimant presented the report of a biopsy conducted on June 1, 1992. (DX-59). Dr. Buddington diagnosed "poorly differentiated adenocarcinoma, anthracosis and fibrosis consistent with coal workers pneumoconiosis."

Pulmonary Function Studies

Pulmonary function studies may provide some of the acceptable documentation for a reasoned medical opinion diagnosis of pneumoconiosis at 20 C.F.R. § 718.202(a)(4). Total disability may be established through a preponderance of qualifying pulmonary function studies. The quality standards for pulmonary function studies are located at 20 C.F.R. § 718.103 (2004) and require, in relevant part, that (1) each study be accompanied by three tracings, ***Estes v. Director, OWCP***, 7 B.L.R. 1-414 (1984), (2) the reported FEV1 and FVC or MVV values constitute the best efforts of three trials, and, (3) for claims filed after January 19, 2001, a flow-volume loop must be provided.

The administrative law judge may accord lesser weight to those studies where the miner exhibited "poor" cooperation or comprehension. ***Houchin v. Old Ben Coal Co.***, 6 B.L.R. 1-1141 (1984); ***Runco v. Director, OWCP***, 6 B.L.R. 1-945 (1984). To be qualifying, the regulations provide that the FEV1 and either the MVV or FVC values must be equal to or fall

below those values listed at Appendix B for a miner of similar gender, age, and height, or the ratio of the FEV1/FVC equals 55% or less. Assessment of the pulmonary function study results is dependent on the miner's height, which has been recorded most recently from 68 to 70 inches. I therefore find that the Claimant's height is 69.3 inches for purposes of evaluating the pulmonary function studies. ***Protopappas v. Director, OWCP***, 6 B.L.R. 1-221 (1983). *See* ***Toler v. Eastern Associated Coal Corp.***, 43 F.3d 109, 114, 19 B.L.R. 2-70 (4th Cir. 1995).

The following pulmonary function studies are included in the evidence submitted on modification:

DATE	***EXH.***	***PHYSICIAN***	***FEV1***	***FVC***	***%***	***MVV***	***QUALIFY***
HT/AGE							
01-05-99	DX-49	[Tankersly]	1.49	2.07	72%		Yes
70"/70							

A physician who reviewed this test reported that it indicated "moderate restriction." (DX-29). The technician reported "good" effort and cooperation.

This test was initially reviewed by Dr. Flowers, who pronounced it "acceptable." (DX-49). On November 9, 1999, Dr. Kirk Hippensteel reported on his review of this study and concluded that it s an invalid study. He provided a detailed analysis for his conclusions. (DX-50). Similar, the employer secured the opinion of Dr. Fino, who also reviewed this study and also concluded that it was invalid. (DX-50). Both Drs. Fino and Hippensteel are board certified in internal medicine and pulmonary disease. Dr. Castle also reviewed this test and deemed it invalid, stating that it would not be an accurate indicator of the Claimant's respiratory impairment. (DX-52). Although he originally considered this study valid, Dr. John Michos reconsidered after examining the invalidation opinions from the employer's experts. (DX54).

12-06-99	DX-52	Castle	1.53	2.23	69%	29	Yes
69"/71	(post bronchodilator)		1.64	2.36	70%		Yes

Dr. Castle reported that the FVC was "artificially reduced" because the Claimant did not exhale long enough. The was "severe degree of obstruction." Dr. Castle also stated that the lung volumes were normal, and that there was no restriction. Tracings are attached.

04-20-00	DX-61	Smiddy	1.43	2.36	61%	26	Yes
69"/71	(post bronchodilator)		1.67	2.59	64%	27	Yes

Dr. Smiddy noted "good" cooperation and effort in the performance of this test. He observed coughing. Dr. Michos reviewed this study, and pronounced it "not acceptable" because he was unable to calculate the FEV1 and FVC values from the tracings that wee provided.

11-07-00	DX-62	Castle	1.47	2.27	65%	37	Yes
68"/72	(post bronchodilator)		1.74	2.69	65%		No

Legible tracings are attached. Dr. Castle indicated that these are valid studies indicative of a moderate airway obstruction with a significant response to bronchodilators. There was no restriction. Dr. Michos also considered this a valid test, although he observed suboptimal MVV performance.

08-08-01	DX-66	Smiddy	1.34	2.34	67%		Yes
	(post bronchodilator)		1.58	2.77	57%		No

Dr. Smiddy observed "good" effort and cooperation.

04-30-02	CX-4	Narayanan	1.33	2.11	63.03%		Yes

By endorsement, Dr. Narayanan agreed with a technician's observation that the Claimant expended good effort and cooperation. Tracings are attached.

02-11-03	CX-5	Narayanan	1.20	2.04	58.82		Yes

By endorsement, Dr. Narayanan agreed with a technician's observation that the Claimant

expended good effort and cooperation. Tracings are attached.

01-08-04	CX-6	Narayanan	1.03	1.89	Yes

By endorsement, Dr. Narayanan agreed with a technician's observation that the Claimant expended good effort and cooperation. Tracings are attached.

01-19-05	CX-7	Narayanan	1.21	2.12	Yes

A technician noted good effort. Tracings are attached. The results were read by Dr. Narayanan.

Arterial Blood Gas Studies

Arterial blood gas studies may provide some of the acceptable documentation for a reasoned medical opinion diagnosis of pneumoconiosis at 20 C.F.R. § 718.202(a)(4). Total disability may also be established by qualifying blood gas studies under 20 C.F.R. § 718.204(b)(2)(ii) (2004). In order to be qualifying, the PO2 values corresponding to the PCO2 values must be equal to or less than those found at the table at Appendix C.

The following blood gas studies are included in the record on modification:

DATE	***EXH***	***PHYSICIAN***	***PCO2***	***PO2***	***QUALIFY***
12-06-99	DX-52	Castle	44.6	73.5	No

Dr. Castle indicated that this test was a "normal ABGs for patient's age and altitude."

11-07-00	DX-62	Castle	48.1	69.3	No
05-29-02	DX-70B	Castle	42	77.8	No

Medical Opinions

Dr. Joseph Smiddy

Dr. Smiddy has been treating the Claimant for some time for his pulmonary condition. The Claimant has submitted a series of progress notes, letters and opinions from Dr. Smiddy.

Submitted with the Claimant's request for modification is the medical report, dated July 13, 1998, from Dr. Smiddy.[15] (DX-48). Mr. Beverly was referred to Dr. Smiddy with complaints of shortness of breath, wheezing and cough. The doctor also noted that the Claimant "worked extensively in coal mining where he had heavy exposure to coal dust as well as rock dust." Dr. Smiddy recited this "Past Medical History":

> This patient has an extensive past medical history and carried to us in hand a note from Dr. John G. Byers[16] indicating a diagnosis of scar carcinoma, "an adenocarcinoma that formed around a coal macule", and documenting a legal, as well as medical diagnosis, of pneumoconiosis. The resected lung specimen showed coal macules consistent with pneumoconiosis.

On physical examination, Dr. Smiddy detected "[s]lightly decreased breath sounds. No rales, rubs, rhonchi." He observed no "clubbing, cyanosis, edema or phlebitis." Dr. Smiddy

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[15] This report was generated prior to the date of the Decision and Order issued by Administrative Law Judge Tureck. Taken alone, it is questionable whether modification on the basis of such evidence would render justice under the Act. *See* generally ***McCord v. Cephas***, 532 F.2d 1377 (D.C. Cir. 1976).

[16] In a letter report, dated April 8, 1997, Dr. John G. Byers noted that the Claimant was found to have "an adenocarcinoma of the lung which had formed around a central scar" which thus represented a "scar carcinoma," a finding that prompted Dr. Byers to characterize it as a "legal as well as medical diagnosis of 'black lung.'" (DX-13). Dr. S. K. Paranthaman examined the Claimant on July 31, 1997, and while he found that Mr. Beverly was afflicted with pneumoconiosis and lung cancer, he also opined that the cancer was unrelated to the pneumoconiosis. (DX-14).

concluded that Mr. Beverly "has a well documented diagnosis of coal workers pneumoconiosis with a severe degree of disability of long-standing duration."

Dr. Smiddy also submitted a "To whom it may concern" letter, dated August 23, 1999, in which he concluded:

> This patient is 100% totally and permanently disabled by coal workers pneumoconiosis. Please note the attached documenting records. This patient was documented to have pneumoconiosis at the time of his previous lung resection showing documented coal macules.

(DX-48).

Dr. Smiddy submitted a pulmonary evaluation in the form of a "progress report" dated April 13, 2000. (DX-58). The Claimant presented with "severe shortness of breath and severe chronic exercise limitation." Dr. Smiddy noted "[k]nown documented coal workers' pneumoconiosis." He further made reference to "[p]rior B-Reader chest x-rays [that] have documented a significant degree of coal workers' pneumoconiosis and the patient had a previous biopsy 06-01-92 showing both adenocarcinoma in a wedge resection as well as significant coal workers pneumoconiosis documented by biopsy." Dr. Smiddy assessed the Claimant as "100% total and permanent disability by long-standing, well documented, biopsy proven coal workers pneumoconiosis."

Dr. Smiddy diagnosed in a Progress Note dated October 12, 2000 that the Claimant has pneumoconiosis, bronchitis and chronic obstructive pulmonary disease. (DX-66). He reported on April 12, 2001, based on his examination in a follow-up visit, that Mr. Beverly had a "[h]istory of lung cancer (It is of interest that his pathology report at the time of lung cancer resection showed significant coal worker's pneumoconiosis.), with underlying and associated bronchitis and pneumoconiosis associated obstructive lung disease." He noted that the Claimant had smoked in the past. (DX-66). He reached similar conclusions in a July 19, 2001 report. He reiterated this diagnosis on September 27, 2001. (DX-66).

In another letter report, dated July 8, 2003, and addressed to Dr. Shamiyeh, Dr. Smiddy reported that he had reviewed a CT scan of the chest dated June 25, 2004. Dr. Smiddy also cites the PET scan, and notes findings strongly suspicious of malignancy. In addition, he reviewed slides. The doctor recounted that Mr. Beverly complained of chronic cough, wheeze and shortness of breath. The "past medical history" also notes that "[i]t was thought by several individuals that this carcinoma seemed to arise in an area of Coal Workers Pneumoconiosis." Dr. Smiddy's diagnoses included "underlying COPD," pneumoconiosis and prior history of lung cancer. (CX-9).

In progress notes, dated September 11, 2003, Dr. Smiddy noted that the Claimant "had a lung cancer which arose from a previous known area of pneumoconiosis." Progress notes from March 27, 2003 reflect that "[w]e obtained the original pathology report and also reviewed the tissue with Dr. Marcus Grimes and did indeed see severe pneumoconiosis with carcinoma arising in an area of pneumoconiosis." In a progress note dated October 30, 2002, Dr. Smiddy wrote that "[t]he question had been recently raised that the carcinoma could have arisen from pneumoconiosis."

In a letter report, dated January 13, 2005 and addressed "to whom it may concern," Dr. Smiddy reported on a review of the Claimant's chart. He noted that Mr. Beverly has underlying COPD, Coal Workers Pneumoconiosis and coronary artery disease. He also found it

> interesting in our records to note that the patient, at the time of his original

> surgery, was thought to have a lung cancer arising in a site of Coal Workers Pneumoconiosis and to be related directly to Coal Workers Pneumoconiosis. ... The pathologist at Intermountain Pathology at Abingdon as poorly differentiated adenocarcinoma with anthracosis and fibrosis consistent with Coal Workers Pneumoconiosis. We subsequently obtained those slides and reviewed these slides in detail with Dr. Marcus Grimes, Pathologist at Wellmont Holston Valley. It was thought by several individuals, including the previously named pathologist and myself that this carcinoma seemed to arise in an area of Coal Workers Pneumoconiosis. It seems that this would be an incidence of carcinoma relating Coal Workers Pneumoconiosis based upon the available evidence.

Dr. Smiddy diagnosed "Lung cancer related to Coal Workers Pneumoconiosis with recurrence of lung cancer related to Coal Workers Pneumoconiosis." He also found "[u]nderlying COPD[,]" and "Coronary artery disease." (CX-8).

Dr. Smiddy is board-certified in internal medicine, with a subspecialty in pulmonary disease. He has been a Clinical Instructor of Medicine at the Georgetown University, and is currently a Clinical Professor of Medicine att he Quillen-Dishner School of Medicine.

Miscellaneous Treatment Notes

The Claimant submitted a number of exhibits in support of the petition for modification, among them reports dating from 1992.[17] There is also a surgical pathology report based on the right upper lobe biopsy conducted on June 1, 1992. The pathologist at that time diagnosed "poorly differentiated adenocarcinoma," along with "anthracosis and fibrosis consistent with coal workers pneumoconiosis." The pathologist observed that adjacent to a dense fibrotic scar there is "dense fibrosis with anthracotic pigment with small fibrotic nodules measuring up to 3 mm in diameter." (DX-59).

Dr. Souhail Shamiyeh

Dr. Souhail Shamiyeh submitted an undated "To whom it may concern" letter stating that "Mr. Beverly suffers from a history of severe pneumoconiosis, COPD, and S/P resection of lung cancer." He recited that the Claimant had been seen on April 1, 1999 by Dr. Smiddy, who thought that he had "significant pneumoconiosis that interferes with his activities." Dr. Shamiyeh also reported that "[the Claimant] was also thought to have a scar carcinoma, possibly related to his pneumoconiosis." He concluded that the Claimant "remains disabled secondary to his pneumoconiosis and his other underlying problems."

The Claimant was hospitalized at the Wellmont Lonesome Pine Hospital from October 28 to November 4, 2004. (EX-20). Dr. Shamiyeh wrote in the discharge summary that Mr. Beverly had been admitted with atrial fibrillation. Dr. Shamiyeh's discharge diagnoses were:

1. A fib flutter with rapid ventricular rate.
2. Hypokalemia.
3. Congestive heart failure.
4. Lung CA with mets.
5. Hypothyroidism.
6. Anemia.

[17] Strictly speaking, this evidence would not be considered in evaluating a duplicate or subsequent claim because it had been generated prior to the final denial of the Claimant's previous claim.

7. Low platlets.
8. Confusion.

On December 13, 2004, the Claimant went to Dr. Shamiyeh for a follow-up. He noted the following impression:

1. Lung CA. …
2. COPD. I told him to go back on the Advair and continue with the Xopenex at this point.
3. CAD. Congestive heart failure. He is doing well at this point.
4. Anticoalgulation. Obsreve. Will continue to monitor his PT/INR.
5. Evidence for [oral] yeast infection …
6. Anemia. F/U with Cancer Center.

(EX-21).

In another letter, dated February 22, 2005, Dr. Shamiyeh opined that the Claimant is totally disabled, and concluded as well that the Claimant "has lung cancer related to coal workers' pneumoconiosis with recurrence of lung cancer related to coal workers' pneumoconiosis." Dr. Shamiyeh reported that Dr. Smiddy agreed with these conclusions. (CX-12).

Dr. David Miller

Dr. Miller submitted a consultation report, dated July 22, 2004. (EX-12). He reviewed the Claimant's history of present illness, noting that Mr. Beverly had "noted the onset of increased shortness of breath within the past six months[.]" Respiratory complaints included shortness of breath on exertion. History included "triple bypass ... in 1994 and lung surgery[.]" Dr. Miller noted a smoking history of one-half to one pack per day for over 30 years.[18] On physical examination, the lungs were clear to percussion and auscultation. Dyspnea on exertion noted, and "normal respiratory excursion without effort."

Dr. Miller's assessment included poorly differentiated adenocarcinoma of the right upper lobe, with evidence of recurrent disease in right suprahlier area. PET scan was positive for metastatic disease. Mr. Beverly also suffers, *inter alia*, from coronary artery disease, chronic obstructive pulmonary disease and coal workers' pneumoconiosis. Dr. Miller told the Claimant that his cancer is not curable by any means, but he also recommended chemotherapy.

Dr. Miller offered a "To Whom it may Concern" letter, dated January 21, 2005, stating that the Claimant is totally and permanently disabled by coal workers' pneumoconiosis. He also opined that, in addition, Mr. Beverly is totally disabled from his lung cancer. Dr. Miller concluded that "[i]n view of his occupation of having been a coal miner, my opinion *is* that this *could have* increased his risk for development of his current lung cancer." (CX-13). The italicized portions are handwritten additions to this report.

Dr. Gregory J. Fino

Dr. Fino submitted a one-page medical report, dated September 21, 2004. In the one page report, he opined that there were no changes consistent with a coal mine dust associated occupational lung disease. Dr. Fino is board-certified in internal medicine, pulmonary disease, and is a B-reader. (EX-13).

[18] In his report dated March 8, 1995, Dr. German Iosif recounted that the Claimant said that he had smoked between one-half and one pack per day for "at least 45 days." (DX-45).

Dr. P. Raphael Caffrey

Dr. Caffrey submitted a Pathology Supplemental Report, dated October 19, 2004. (EX-14). Dr. Caffrey reviewed medical records submitted by employer. Dr. Caffrey commented on his examination of six biopsy slides from a needle biopsy of the right upper lobe. He identified "neoplastic cells," a "small area of fibrosis without pigment," and "[o]ne tiny focus with minimal amount of anthracotic pigment." He elaborated

> ... One of the six slides has been marked with an "X" by the surgical pathologist and at the end ... are cells ... consistent with neoplastic cells. Adjacent to these neoplastic cells there is a mild to moderate infiltrate of mononuclear cells. There is no anthracotic pigment around these neoplastic cells. One of the six needle biopsy pieces shows focal fibrosis with no anthracotic pigment and no cancer cells. In one of the other six needle biopsy pieces there is a very slight amount of anthracotic pigment."

Dr. Caffrey noted a coal mine work history of 30 years and a smoking history of 36 3/4 pack/years. He concluded at length:

> In my original report dated January 26, 1996 following my review of records, and the surgical pathology slides I made a diagnosis of moderate to poorly differentiated adenocarcinoma of the lung and said the patient had simple CWP. ... The facts still remain in my opinion that there is no cause and effect relationship between the coal mine employment and Mr. Beverly's carcinoma of the lung. Mr. Beverly had a significant smoking history of some 30+ years. The cause of Mr. Beverly's lung cancer in my opinion is his years of smoking cigarettes. I also reported that the majority of coal miner fatality studies have shown that lung cancer is slightly less common in coal miners than in comparable populations.
>
> I now discuss Dr. Byers, Jr's letter of April 8, 1997[.] ... I do not understand how Dr. Byers arrived at [his] opinion because I certainly did not report that in my consultation of January 26, 1996; I described no such scar that Dr. Byers mentions. ... In an independent pathology opinion by Dr. Crouch in a report dated December 5, 2000 the Doctor diagnosed poorly differentiated carcinoma consistent with lung primary, and dust deposition and changes consistent with simple CWP and makes a comment ... : "*The changes in the surrounding lung tissue are consistent with simple coal workers' pneumoconiosis of at least mild severity*." Dr. Crouch makes no mention of a "scar" in the biopsy material. ...Again I am not certain how Dr. Byers arrived at the fact that there was a scar associated with the carcinoma in Mr. Beverly's case. If indeed that was reported either on an x-ray or a pathology interpretation, did not see it in my pathology interpretation, and even if it was present it definitely was not the cause of the carcinoma, but the fibrosis or scarring would be a desmoplastic reaction to the tumor and not the cause of the tumor or the cancer.
>
> ... I definitely disagree with [Dr. Smiddy's statement that the Claimant is totally disabled by coal workers' pneumoconiosis because] Dr. Smiddy absolutely does not give any objective evidence for that statement. Dr. Smiddy ignores the fact that this patient previously had a myocardial infarction with a CABGx3. ... The pulmonary problems that Mr. Beverly suffers from unfortunately are due to the fact that he has recurrent carcinoma; he does have COPD, which in my

opinion is mainly due to his 30+ years of smoking cigarettes. In fact Dr. Castle recorded on June 17, 2002 the patient had a history of smoking approximately 46 years. Mr. Beverly has significant cardiac disease as well as abdominal aortic aneurysm and hypertension. He also does have pathologic pneumoconiosis but in my opinion the simple CWP by itself would not be severe enough to cause any significant pulmonary disability. ...

... The majority of chest x-ray interpretations ... indicates to me the patient did not have significant or diffuse CWP. ...

In summary, Mr. Beverly has the following medical diseases of significance:

1. Carcinoma of the lung – definitely not caused by or due to his employment in the coal mining industry.
2. Coronary artery disease ... not caused by or in any way related to employment in the coal mining industry
3. Abdominal aortic aneurysm ...
4. Hypertension ...
5. Chronic obstructive pulmonary disease – this in fact in my opinion is due to is multiple years of smoking cigarettes rather than the simple CWP. I do agree that simple CWP in a susceptible individual with a significant degree of CWP could have emphysema and bronchitis due to CWP, but as evidenced by the pathology reports and evidenced by the radiology report this gentleman does not have a significant degree of CWP.

* * *

In conclusion, the fact that Mr. Beverly worked in the coal mines for approximately 30, this did not cause him any significant pulmonary disability, and certainly did not cause or contribute to the significant medical problems the patient has, namely carcinoma of the lung, and cardiac problems following his MI and CABG. With the smoking history Mr. Beverly has it is my objective opinion he would suffer from the same serious medical diseases whether or not he ever worked in the coal mines.

Dr. Caffrey is certified as a fellow in anatomical and clinical pathology. He served as Assistant Clinical Professor of Pathology at the University of Kentucky School of Medicine from 1964 until 1995. (EX-14).

Dr. Caffrey testified at a deposition on March 28, 2005. Dr. Caffrey was asked about the pathology report from Dr. Buddington, and testified to his agreement with the latter's diagnoses of poorly differentiated adenocarcinoma and coal workers' pneumoconiosis. (EX-27 at 6-7). He stated that the type of cancer found here is "one form of carcinoma that's seen in primary cancers of the lung." (*Id.* at 7-8). Dr. Caffrey likewise concurred with the findings by Drs. Crouch and Tomashefski to the extent of their opinions regarding the presence of cancer and "changes consistent with simple coal workers' pneumoconiosis."

He did not agree with Dr. Bechtel's original diagnosis of "infiltrating poorly differentiated carcinoma," and agreed that that diagnosis may have been based to some extent on the Claimant's history. (EX-27 at 10).

Smoking is the most common cause of lung cancer, according to Dr. Caffrey. With respect to the Claimant's smoking history, Dr. Caffrey noted a variance in the Claimant's records. Regardless, "the patient had a very significant smoking history particularly in the

amount that he smoked over the number of years that the individual smoked." (EX-27 at 12-13). Dr. Caffrey agreed with the statement that the Claimant quit smoking in 1992 would not prevent this 2004 cancer from being a new cancer caused by that earlier smoking. (EX-27 at 14).

With respect to the relationship between coal workers' pneumoconiosis and lung cancer, Dr. Caffrey testified that "there's been a lot a studies done and the incidence of pure coal workers pneumoconiosis is not documented to cause cancer of the lung." (*Id*. at 15). He went on to say that coal dust is not a carcinogen, although silica has been shown to be carcinogenic. He added that "silica is in individuals who have silicosis not in individuals who have simple coal workers pneumoconiosis." (*Id*. at 16-17).

Dr. Caffrey was asked about conclusions reached by Drs. Byers and Smiddy that the Claimant suffered from a "scar" carcinoma that arose from coal workers' pneumoconiosis. He explained:

> Well first of all I saw no records that documented before the individual developed lung cancer, where the x-ray show he had a scar, a fibrosis in that area in which the cancer was developed. That's the first reason.
>
> And second is studies have shown that in essentially all of most all cases where people say there is a scar associated with the cancer, the scar is due to the cancer.

(EX-27 at 18-19) (citing studies and textbook).

Dr. Caffrey observed that Dr. Buddington had not related the scar to either coal dust exposure or to coal workers pneumoconiosis. He did not find any evidence of pneumoconiosis within the cancer in the 1992 slides. In any event, he noted that the behavior of cancer cells allows for the possibility that the cancer would spread and engulf lesions that are created by pneumoconiosis. This would not mean that there is a cause and effect relationship between the two disease processes. (EX-27 at 22-23).

He emphatically disagreed with Dr. Shamiyeh's assertion that the cancer found here was related to coal workers' pneumoconiosis. Dr. Caffrey noted that Dr. Shamiyeh provided no rationale or basis for this conclusion other than to refer to reports by Dr. Smiddy. That physician in turn would refer to Dr. Byers as authority for the opinion that the cancer was caused by the Claimant's pneumoconiosis. In Dr. Caffrey's view, these statements were made without a reliable or a factual basis. (EX-27 at 24). He likewise disagreed with Dr. Miller's conclusion that there "could have" been a relationship between coal workers' pneumoconiosis and lung cancer.

Dr. Caffrey concluded:

> [H]e has what I would call pathologic coal workers pneumoconiosis. I don't believe he has legal coal workers pneumoconiosis.
>
> * * *
>
> [H]e definitely has lung cancer.
>
> * * *
>
> In my opinion it is definitely not in anyway related to his coal workers pneumoconiosis.

(EX-27 at 26). With respect to respiratory disability, he opined:

> I'm sure that an individual who has lung cancer has some disabling pulmonary problem. ... But it would be my opinion if indeed he did not have lung cancer, if he just had simple coal worker pneumoconiosis, and if he did not have heart problems, and hypertension, the simple coal workers pneumoconiosis would

not be disabling him.

(EX-27 at 26-27). He added that the Claimant's pulmonary disability was most likely due to his smoking, which resulted, in his view, not only in the lung cancer but also in Mr. Beverly's asthmatic bronchitis and chronic obstructive pulmonary disease. (*Id.* at 28). He thought that the lesions associated with the Claimant's coal workers pneumoconiosis "were such that they would not have disabled him." (*Id*.).

Dr. James Castle

Dr. Castle reviewed medical documents at the request of the employer and submitted a consultant's report on November 8, 2004. (EX-15). Dr. Castle had previously examined the Claimant five times.[19] After this latest review, he concluded:

> After a very thorough and extensive review of all the additional medical data submitted ... [i]t remains my opinion with a reasonable degree of medical certainty ... that Mr. Roy Beverly does have pathologic evidence of minimal, simple coal workers' pneumoconiosis.
>
> ... He worked for at least 28-30 years in the mining industry and last worked in 1984. ... This did involve some heavy labor.
>
> Another risk factor for the development of pulmonary disease is that of tobacco abuse. He had a history of smoking for approximately 40 or more years at a variable rate of between 1/2 - 1 1/2 packs of cigarettes daily. This is a sufficient enough history to have caused him to develop chronic obstructive pulmonary disease[.] ... [H]e did develop evidence of a bronchogenic carcinoma requiring right upper lobectomy in 1992 and developed a recurrence of this process in 2004 with metastatic disease. The resection of a portion of the lung as well as lung cancer and the treatment thereof will result in a significant increase in symptoms and can result in significant physiologic changes as well.
>
> Another risk factor for the development of pulmonary symptoms is that of asthmatic bronchitis. Mr. Beverly has a history of significant nasal allergies associated with increased difficulty breathing occurring in paroxysms when exposed to various perfumes, cleaning odors, etc. This has been associated with a significant degree of reversibility in pulmonary function testing indicating the presence of asthmatic bronchitis.
>
> Another risk factor for the development of pulmonary symptoms is that of severe cardiac disease. ...
>
> It is my opinion and the opinion of the majority of radiologists and B-readers that there was no evidence of coal workers' pneumoconiosis radiographically. That was further corroborated by a CT scan of the chest which did not show evidence of coal workers' pneumoconiosis.
>
> The last valid physiologic studies that were done were those obtained on 8/8/01 by Dr. Smiddy. The study showed evidence of moderate airway obstruction with a very significant degree reversibility indicating the presence of tobacco smoke induced asthmatic bronchitis. Coal workers' pneumoconiosis does not cause a significant degree of reversibility on pulmonary function testing.

[19] It is unnecessary to set forth the details of these previous examinations. Dr. Castle summarizes his previous findings and conclusions.

When coal workers' pneumoconiosis causes impairment, it does so by causing a mixed, irreversible obstructive and restrictive ventilatory defect. In this case it has been shown repeatedly that he has a normal total lung capacity and no evidence of any restriction. He has also demonstrated markedly reversible airway obstruction. These findings are not consistent with a coal mine dust induced lung disease. Therefore, for the reasons stated above, it is my opinion that the disabling degree of respiratory impairment is related to tobacco smoke induced asthmatic bronchitis rather than a coal mine dust induced lung disease.

* * *

When the lung was resected in 1992 because of bronchogenic carcinoma, the pathologist and several pathology consultants indicated that there was evidence of minimal, simple coal workers' pneumoconiosis. It was noted that the size and number of lesions represented in the tissue specimens were insufficient to cause a clinically significant degree of pulmonary impairment or disability. This type of finding is not unexpected. It is entirely conceivable that one can have pathologic evidence of coal workers' pneumoconiosis with such minimal involvement that it does not impact upon either ventilatory function or radiographic changes. That was indeed the case.

[The Claimant] does have ... simple coal workers' pneumoconiosis.

It is my opinion with a reasonable degree of medical certainty that Mr. Beverly does have a moderate degree of airway obstruction with a very significant degree of reversibility due to tobacco smoke induced asthmatic bronchitis. It is my opinion that this process would render him permanently and totally disabled. It is my opinion that he is not permanently and totally disabled as a result of coal workers' pneumoconiosis or as a result of any other coal mine dust induced lung disease. It is also my opinion ... that he is permanently and totally disabled as a whole man because of his recurrent bronchogenic carcinoma, severe coronary artery disease with dilated cardiomyopathy, and other ,medical problems. None of these conditions are related to coal workers' pneumoconiosis.

It is my opinion with a reasonable degree of medical certainty that the bronchogenic carcinoma from which he suffers was not caused by, contributed to, or aggravated in any way by coal mine dust exposure. The IARC (International Agency for Research in Cancer) has indicated that there is inadequate evidence in humans for the carcinogenicity of coal dust. ... Therefore, it remains my opinion that coal mine dust exposure played no role in the development of his lung cancer.

Dr. Castle is board-certified in internal medicine and pulmonary disease. He is also a B-reader, and has an academic experience, most recently serving as a Clinical Professor of Medicine at the University of Virginia. (EX-15).

The deposition of Dr. Castle was taken on March 21, 2005. (EX-26). The questioning focuses on the numerous examinations conducted by him. Dr. Castle was questioned about bronchial asthma and stated that it is an "inflammatory disease of the lungs ... manifested by recurrent paroxysms or episodes of wheezing, shortness of breath, and cough. It is significantly reversible when bronchodilators are administered to the individual." He emphasized that it is not related to coal workers' pneumoconiosis and is not caused by coal mine dust exposure." (EX-26 at 6).

Dr. Castle acknowledged that pneumoconiosis was found "pathologically," but stated that

he found no "clinical evidence of pneumoconiosis." He emphasized that "[l]ung cancer is not related to coal dust exposure or to coal workers' pneumoconiosis." (*Id.* at 7). (*See id*. at 9). The cancer was caused by Mr. Beverley's smoking. Regarding his final examination, Dr. Castle remarked:

> Again, the examination was essentially the same. The conclusions were essentially the same. At this time, he had some problems with a cardiac arrhythmia. He still had pathologic evidence of simple coal worker's pneumoconiosis. It was my opinion that his pulmonary function studies were due to his asthmatic condition, as well as tobacco smoke-induced asthmatic bronchitis. We were not able to perform any pulmonary function studies at that time because he had a letter indicating that he should not perform pulmonary function studies.
>
> I did note that pulmonary function studies performed by Dr. Smiddy on 8-8-01 were valid and showed evidence of moderate airway obstruction with a very significant degree of reversibility. It remained my opinion that he was disabled due to his asthmatic bronchitis and was not disabled due to coal workers' pneumoconiosis.

(EX-26 at 10).

Dr. Castle was asked about pulmonary function testing conducted by the Stone Mountain Health Services. He opined that the last of these, conducted on January 19, 2005, was invalid. He also appeared to question a study performed on January 8, 2004. *Id*. at 13. He emphasized that studies with only a pre-bronchodilator trial, a pulmonary function study would not adequately measure reversibility.

Dr. Castle was asked about the PET scans that had been conducted. He explained that such tests primarily are used to "detect and stage cancer." He further explained that cancer has "increased metabolic activity, and this scan will detect increased metabolic activity[.]" He also testified that he would not expect to see the kind of metabolic activity in coal workers' pneumoconiosis. He also reviewed a CT scan, and opined that, while the scan showed cancer, it did not demonstrate coal workers' pneumoconiosis. (*Id*. at 18).

He stressed that it was not unusual to see pathologic evidence of pneumoconiosis without corresponding signs in a chest x-ray or CT scan:

> ... One can have a minimal amount of changes present that could be seen with a microscope, and remember, that means that we can't see it with the naked eye, and if you cannot see it with the naked eye; you would not see it on chest x-ray or a CT Scan, but it could be there microscopically and we say therefore that it is present pathologically. That would be the gold standard for the diagnosis of the disease process. If you don't see it pathologically, then it certainly can't be there. If you do see it pathologically, it can be to such minimal degree that you can't pick it up clinically or in any other way.

(EX-26 at 19).

Dr. Castle disagreed with Dr. Smiddy's opinion that the Claimant's lung cancer was caused by his pneumoconiosis:

> I totally disagree with that. I'm not aware of any evidence in the medical literature to indicate that cal workers' pneumoconiosis is associated with lung cancer. In fact, the IARC, or the International Agency for Research in Cancer, has indicated that coal dust is not a carcinogen, and that means that coal dust does not cause cancer and that it's not been associated with the development of lung

> cancer in humans or in animals, so I'm not aware of any evidence to indicate a link between coal workers' pneumoconiosis and lung cancer.
>
> * * *
>
> ... Doctor Caffrey did a nice review and pointed out that current pathologists and pathology thinking is that lung cancer may cause a desmoplastic or a scarring type of reaction rather than a scar causing the lung cancer, so the current thought is that scars don't develop into cancer, but part of the cancer process is that it may produce some scar tissue.

(EX-26 at 20-21). Dr. Castle disagreed with the opinions of Drs. Smiddy, Shamiyeh and Miller. With respect to the latter's opinion that cancer was associated with Mr. Beverly's pneumoconiosis, Dr. Castle noted that Dr. Miller appeared to qualify his final conclusion that pneumoconiosis played a role in the development of the cancer. (*Id*. at 22-23).

After testifying that the Claimant indeed has pathologic evidence of pneumoconiosis, Dr. Castle concluded that he does not suffer from a chronic lung disease or pulmonary impairment that has been related to, aggravated by, or connected to his coal dust exposure. The doctor also concluded that the Claimant suffers from a respiratory impairment:

> He has very significantly reversible airway obstruction without restriction or diffusion abnormality that is related to his tobacco smoking habit and bronchial asthma.
>
> * * *
>
> [This respiratory impairment] would prevent him from returning to that degree of work [demanded by his coal mine employment].
>
> * * *
>
> It is not related in any way [to Mr. Beverly's coal dust exposure or simple coal workers' pneumoconiosis].

Dr. Erika C. Crouch

A Pulmonary Pathology Consultation Report, dated December 5, 2000, was submitted by Dr. Crouch. Dr. Crouch evaluated a "single glass slide" and the "corresponding surgical pathology report" and St. Mary's Hospital records. On microscopic examination, she found:

> The designated right upper lobe biopsy shows a poorly differentiated carcinoma consistent with a lung primary. Areas of surrounding lung show multiple dust macules characterized by irregular black to dark brown particles consistent with coal dust in combination with short, needle-like, and weakly birefringent particles consistent with silicates. No silicotic nodules are identified. In addition, no coal dust type nodules or larger lesions are observed in the present biopsy.

Dr. Crouch diagnosed "poorly differentiated carcinoma consistent with lung primary" and "dust deposition and changes consistent with coal workers' pneumoconiosis." She further commented:

> A single histologic section from a single lobe is insufficient for a definitive pathologic assessment of pneumoconiosis. Nevertheless, the changes in the surrounding lung are consistent with simple coal workers' pneumoconiosis of at least mild severity. Lesions of the size and number represented in this biopsy are insufficient to cause any clinically significant degree of pulmonary impairment or disability. However, the presence of more numerous or larger

> lesions in other lobes cannot be excluded. Additional clinical correlation is needed. ... Coal workers' pneumoconiosis is also not associated with an increased risk for the development of lung cancer. Although the role of silicosis in the development of lung cancer remains controversial, no silicotic nodules are observed in the current specimen.

Dr. Crouch is board-certified in anatomic pathology and is a Professor of Pathology & Immunology at the Washington University in St. Louis. (DX-65).

Discussion

As noted above, the Claimant has established total respiratory disability and is entitled to an adjudication of his claim on the basis of the entire administrative record to determine whether his total disability is due to pneumoconiosis.

Disability Causation

Benefits are provided under the Act for, or on behalf of, miners who are totally disabled due to pneumoconiosis. 20 C.F.R. § 718.204(a) (2004). With respect to disability causation, the Secretary's regulations provide that pneumoconiosis must be a "substantially contributing cause" to the miner's total disability. 20 C.F.R. § 718.204(c)(1) (2004). The regulations define "substantially contributing cause" as follows:

> (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or
>
> (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

20 C.F.R. § 718.204(c)(1) (2004).

Upon consideration of the record as a whole, I find that the Claimant has failed to establish disability causation. I credit the more extensive and detailed medical opinions of Drs. Castle, Caffrey, Couch and Fino, who have opined that the Claimant's lung cancer is not derived in any manner from coal workers' pneumoconiosis. I do not accept the premise of the Claimant's experts who have opined a causal relationship between the Claimant's pneumoconiosis and his lung cancer.

Aside from his lung cancer, Mr. Beverly suffers, *inter alia*, from chronic obstructive pulmonary disease. In ***Cornett v. Benham Coal Co.***, 227 F.3d 569, 575, 22 B.L.R. 2-107 (6th Cir. 2000)., the court emphasized that the "legal" definition of pneumoconiosis "'encompasses a wider range of afflictions than does the more restrictive medical definition of pneumoconiosis.'" (quoting ***Kline v. Director, OWCP***, 877 F.2d 1175, 1178, 12 B.L.R. 2-346 (3d Cir. 1989)). *See also* ***Mitchell v. OWCP***, 25 F.3d 500, 507 n.12, 18 B.L.R. 2-257 (7th Cir 1994); ***Eagle v. Armco Inc.***, 943 F.2d 509, 511 n.2, 15 B.L.R. 2-201 (4th Cir. 1991); ***Old Ben Coal Co. v. Prewitt***, 755 F.2d 588, 591 (7th Cir. 1985) (chronic obstructive pulmonary disease meets statutory definition whether or not technical pneumoconiosis).

Notwithstanding, an obstructive pulmonary or respiratory impairment must be proven to have been significantly related to or substantially aggravated by Claimant's coal mine dust exposure. *See* ***Stiltner v. Island Creek Coal Co.***, 86 F.3d 337, 341, 20 B.L.R. 2-246 (4th Cir. 1996). *See generally* 65 Fed. Reg. 79943 (Dec. 20, 2000) (citing cases). I find that there is no persuasive diagnosis of pneumoconiosis in the broad, "legal" sense as the disease is envisioned under the Act and Secretary's regulations. Although the opinions are in sharp contrast with

respect to the relationship between the Claimant's lung cancer and pneumoconiosis, there are also conflicting views with respect to the etiology and nature of the Claimant's chronic obstructive pulmonary disease, and whether that disease also constitutes pneumoconiosis. I credit Dr. Castle's conclusions with respect to the etiology of the Claimant's obstructive pulmonary disease, *viz*. that it is due to smoking rather than coal mine dust exposure. He has explained in great detail how he reached this conclusion in light of the Claimant's clinical testing and examinations.

I duly note that Dr. Smiddy, who has consistently diagnosed total disability due to pneumoconiosis, has been the Claimant's treating physician for many years. The record contains numerous "progress notes" that have been generated by Dr. Smiddy throughout his treatment of Mr. Beverly. I am also aware that Dr. Smiddy is board-certified both in internal medicine and pulmonary disease, and possesses academic teaching experience.

I find that, although he has noted that the Claimant has been a cigarette smoker, Dr. Smiddy does not sufficiently address the extent of this cigarette smoking history. While he is certainly aware of the Claimant's smoking history, Dr. Smiddy in my view does not adequately explain its potential role in the development of a pulmonary or respiratory disability. The Benefits Review Board has held that an Administrative Law Judge may properly discount a physician's opinion as to the causation of a miner's respiratory or pulmonary impairment when it is based on an inaccurate understanding of the miner's smoking history. *See* ***Bobick v. Saginaw Mining Co***., 13 B.L.R. 1-52 (1988); ***Maypray v. Island Creek Coal Co.***, 7 B.L.R. 1-683 (1983).

Further, he accepts the premise, which I do not credit as a matter of general causation, that the Claimant's pneumoconiosis played a role in the development of his lung cancer. I credit instead the views of Drs. Caffrey, Couch and Castle on this point, and note, for example, that Dr. Paranthaman in 1997 had also opined that the cancer was not related to Mr. Beverly's pneumoconiosis. The credibility of a treating physician's opinion may primarily rest on its "power to persuade." ***Eastover Mining Co. v. Williams***, 338 F.3d 501, 513, 22 B.L.R. 2-625 (6th Cir. 2003). *See* ***Jericol Mining, Inc. v. Napier***, 301 F.3d 703, 709, 22 B.L.R. 2-537 (6th Cir. 2002) (tribunal to examine opinions on their merits).

I have considered 20 C.F.R. §718.104(d) (2001), which requires me to evaluate opinions from treating physicians, and note that Dr' Smiddy's opinion would otherwise qualify for elevated status, but because of the inability to establish a causal connection between cancer and pneumoconiosis, I can not credit Dr. Smiddy's opinion.

With respect to Dr. Shamiyeh, I am concerned that he makes no mention of pneumoconiosis in two of his reports that were developed in November and December, 2004. Certainly, he is more focused on the Claimant's coronary disease. Nevertheless, he also noted diagnoses of conditions unrelated to the Claimant's cardiac status. His letters in support of the claim have limited probative value. I recognize that Dr. Shamiyeh is also a treating physician, and have carefully evaluated his conclusions in this light.

I also note that Dr. Tomashefski, in a report dated March 17, 1996, opined that the Claimant's pneumoconiosis would not have precluded mild to moderate physical exertion. (DX-41). On these facts, I will consider that opinion an assessment of total disability due to pneumoconiosis, where even mild pneumoconiosis may qualify as disability causation if it meets the standards set forth in Section 718.204(c).

Finally, as noted above, I accept that the opinions of the employer's experts are more extensive. Their conclusions are well documented and better explained, and their analyses more thorough. In assessing the probative value of such an opinion, I must account for "the

qualifications of the respective physicians, the explanation of their medical opinions, the documentation underlying their medical judgments, and the sophistication and bases of their diagnoses."[20] ***Sterling Smokeless Coal Co. v. Akers***, 131 F.3d 438, 441, 21 B.L.R. 2-269 (4th Cir. 1997). *See* ***Underwood v. Elkay Mining, Inc.***, 105 F.3d 946, 950-951, 21 B.L.R. 2-23 (4th Cir. 1997). In particular, I would emphasize that Dr. Castle has examined the Claimant on five occasions, and has also reviewed, and critiqued, other medical records. This overview lends some additional weight to Dr. Castle's medical opinions. *See* ***Balsavage v. Director, OWCP***, 295 F.3d 390, 397, 22 B.L.R. 2-386 (3d Cir. 2002) (opinion of physician who did not address other medical records accorded less weight).

In the final analysis, I find that the opinions of the employer's experts, in particular those of Dr. Castle, are better documented and reasoned, and preclude a finding of disability causation. *See generally*, ***Clark v. Karst-Robbins Corp.***, 12 B.L.R. 1-149 (1989)(*en banc*); ***Lucostic v. United States Steel Corp.***, 8 B.L.R. 1-46 (1985). I have also carefully considered, and accounted for, the fact that the most recent x-ray interpretations by the well-qualified Dr. Alexander are positive for pneumoconiosis. Although these x-rays were submitted after Dr. Castle's latest opinions were developed, I do not find that this evidence of pneumoconiosis undermines his conclusions to a significant extent, especially in view of the negative interpretations of x-rays taken in January and February, 2005, by Drs. Scott and Wheeler. I accord considerable weight to the negative rereadings of the latest x-rays by Drs. Scott and Wheeler on the basis of their extensive experience and credentials. See ***Worhach***. At the most, the x-ray evidence is in equipoise, does not demonstrate the existence of pneumoconiosis, and does not establish that the Claimant's pneumoconiosis had progressed to the extent beyond that shown in the biopsy or as characterized by Dr. Castle. This fact leads to the conclusion that the extent of the disease is not as great as assumed by the Claimant's experts. Dr. Castle has observed that there is no record of findings on physical examinations that consistently show the effects of an interstitial disease process.

At the most, I find that the medical evidence is in equipoise. Given his burden of persuasion, the Claimant has not satisfied his obligation that his pneumoconiosis either has "a material adverse effect on the [his] respiratory or pulmonary condition" or [m]aterially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment."

Conclusion

Because the Claimant has failed to establish disability causation, an essential element of entitlement, I must find that he has not qualified for benefits under the Act.

Attorney's Fees

The award of an attorney's fee under the Act is permitted only in cases in which Claimant

[20] I am aware that Dr. Caffrey testified with respect to the relationship between cancer and industrial exposure to silica that "silica is in individuals who have silicosis not in individuals who have simple coal workers pneumoconiosis." (EX-27 at 16-17). Silicosis may constitute coal workers pneumoconiosis to the extent it is derived from the inhalation of coal *mine* dust. *See generally*, ***Marshall v. Stoudt's Ferry Preparation Co.***, 602 F.2d 589 (3d Cir. 1979), *cert. denied*, 444 U.S. 1015 (1980). I also conclude that Dr. Caffrey appears to hold to the premise that simple pneumoconiosis is not disabling. Nevertheless, Dr. Caffrey's view does not significantly undermine the strength of his conclusions. Dr. Couch opined that there were no silicotic nodules observed in the current specimen she was asked to review.

is found entitled to benefits. Since benefits are not awarded in this case, the Act prohibits the charging of attorney's fees to the Claimant for representation services rendered in pursuit of the claim.

ORDER

It is hereby **ORDERED** that the claim of Roy Monroe Beverly is **DENIED**.

A

DANIEL F. SOLOMON
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed. At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).